ANIMA MUNDI – THE CHALLENGE OF GLOBALIZATION

Collected Handouts

SYMPOSIUM MUSIC THERAPY

AT THE 3RD WORLD CONGRESS FOR PSYCHOTHERAPY

IN VIENNA, JULY 14TH - 18TH 2002

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Preface

The world of psychotherapy is to meet for the third time in Vienna. Once again we have put together a programme which reflects the progress of psychotherapy and the manifold ways in which it can be applied. Many subjects have not so far been studied in depth and several new subjects have evolved; the development of psychotherapy is a dynamic process. Once again a large number of symposia and workshops and an attractive social programme are also planned.

The symposium music therapy with its affilated keynotes was facilitated by an engaged group of music therapists: Monika Lagler, Karin Mössler, Dr. Dorothea Oberegelsbacher. Without them and the kind support of the Viennese Institute for Music Therapy (WIM), the Austrian Association of Professional Music Therapists (ÖBM) as well as the Working Group 'Music Therapy' of the European Assosiation for Psychotherapy (EAP) leaded by Silke Jochims, the symposium probably would not have come into being. I give my respect and gratitude to them and all the contributing authors. I wish a successful symposium, pleasure and success in pursuance and continuing development of the music therapeutical discipline.

As this will be the last World Congress in Europe for several years (the next two World Congresses will be held in 2003 in Buenos Aires and 2008 in Peking), it is our endeavour to highlight the significanct characteristics of European psychotherapy in a world which increasingly appears to be out of joint. We hope to demonstrate what part psychoterapists can play in this world. On behalf of the World Council of Psychotherapy I would like to invite you to attend the first World Congress in the new millenium and to seek a dialogue with collegues form more than 100 countries all over the world – a globalised world for the psychotherapist, too.

Vienna, July 2002 Alfred Pritz

President of the World Council for Psychotherapy (WCP)

Tuesday

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The building up of a relationship with minimally responsive patients.

Music therapy in early rehabilitation with children

Beziehungsaufbau mit minimally responsive patients.
Musiktherapie in der Frührehabilitation mit Kindern

Karin Mössler

Children, who suffered the loss of all communication channels due to severe brain lesions after a traumatic accident, are in danger to lose the ability to build up a relationship. Therefore it is important that therapeutic offers take place in the rehabilitation plan of this children. The main reason for this importance is the need of human beings to express themselves, to get in contact with others, to share dreams, feelings, ideas,... with others. We would be stuck in our development without the exchange with other people.

In the specific case of minimally responsive patients another fact is important – the psychotrauma. It is very important for the patient to build up trust, build up a relationship to someone. These are conditions to open up oneself and in the following, to get in contact with the traumatic experience of the accident, the severe consequences and the feelings belonging to it, like anger, desperation, helplessness and sorrow. So, without relationship it is not possible to work

therapeutically on the traumatic experience. It is not possible to start a process of sorrow, which is very important for the mental overhaul of the trauma.

I see the chance to get in contact with the minimally responsive patient in a very early state of rehabilitation through music therapy.

´The term "minimally responsive patient" is not a diagnosis. It denotes a syndrom of severe cognitive and motoric limitation due to brain injury. It also includes persons functioning at a somewhat higher level than coma and vegetative state with voluntary movement and behavior`(O´Dell, Riggs 1996). In that case the child is not able to speak, to gesture or to use facial expressions. Therefore it is necessary to search for the resources of the child and work with them. These are vegetative expressions, like breathing, pulse, heartbeat, ..., minimal movements, little vocal expressions, like smacking or sighing and sense-perceptions, like hearing and feeling of physical and emotional touches. These resources are communication mediums and they form the language of the minimally responsive patient. The therapist must learn to understand them.

In music therapy it is possible to work with the child even when he or she doesn´t speak. The music therapist can reach him/her on an emotional level with the help of music and specific musictherapeutic methods, which I´m going to present in the following.
By means of case presentations I analysed three stages of relationship in the musictherapeutic work with minimally responsive patients. In all these levels different topics are important and therefore different musictherapeutic methods are necessary.

In the first stage, which I call ´orientation-stage`, the two main topics are the building up of the Urvertrauen (basic trust) and the patient's ability to manufacture stimula. Because of the traumatic experience of an accident and the severe brain lesions these two abilities are seriously impaired, but are necessary to be able to develop an intrapersonal relationship. In music therapy the first aim is to work on these two assumptions. The interventions and methods which take place in the therapy are:

- Rituals: e.g. singing of welcome- and good bye songs
- Structuring of the therapy lesson: introduction of different stages – I call them active stages and quiet stages – to give orientation and support, to make recognition possible.
- Containing: holding the minimally responsive patient – holding his/her emotions so that he/she can contain them her-/himself in a later stage.

This can be realised in the therapy in form of situation-songs, or instrumental situation music.

- ´Regressive, symbiotic relation offer`: Silke Jochims describes the work with the voice, in detail the singing of children-, evening-, or christmas songs. For her nothing else is able to mediate nearness, safety, warmth and Urvertrauen more than the own voice.

The musical offer in that stage is supporting and accompanying. Melodies and musical motives are in a short scale, are quiet and flowing and are repeating themselves.

Short, simple melodies, which belong to the expressions of the patient and which are suited for repetition are standing in the foreground.

The second stage is called ´relation to oneself` and the main topics are the body- and the self-perception of the minimally responsive patient, which are also seriously impaired. They can be a topic in the therapy only when trust is built up. Without trust the child will be afraid of body-contact.

To perceive oneself, to have a relation to the own body is an assumption for perceiving any other person. Musictherapeutic methods, which support this perception, are the following:

- Body-songs: singing about different parts of the body in improvised or traditional form to make the perception – "these are my borders, these are my fingers, legs,..." – and relaxation possible; these songs are supporting.
- Finger-games: have the same aim as body-songs
- Vibration: vibration as another tactile perception, which goes a bit more under the skin; e.g. putting a lyra to the leg of the child emphasises the song.
- Imitation: this is about experience: listen to what you are making, because that is you. In that way the child gets the ability to build up a relationship to him-/herself, to his or her own actions. E.g. the imitation of vocal expressions.
- ´Echo – counter-transference`: Mary Priestley describes the echo – counter-transference as a reactive form of the counter-transference. It is the phenomenon the music therapist works with when he is going to express the hidden feelings of the patient. This supports the experience of the child: "I hear what I´m feeling".

The last stage, which is going to be described, is the ´relation to another`. This stage is just possible when the child is already able to perceive him-/herself. Here

the minimally responsive patient becomes more and more active, initiative and interactive. The child wants to get in contact with another person and is able to hold and to create a relationship. The abilities of interintentionality, interattentionality and interaffectivity, which are described as signs of interaction by Daniel Stern, become obvious. Now interventions are no more supporting and holding but are following the aim to promote interaction. The child wants to express him-/herself and wants to communicate with his/her surrounding.

The interventions, which are important to support the interaction of the child, are:

- Iso principle by Benenzon
- Perceiving, recognizing and reacting of the child´s actions: to get the child´s interest, concentration and attention. If in this process a musical play develops, which is enough stimulating, the child is going to demand the repetition of the play.
- Affect attunement: which we know from the mother-child-interaction, with the aim to develop a connection between the emotional condition and to express the common inner experience.
- Design of the playing pattern: A relationship is going to be lively as long as it is designed. Therefore playing patterns/musical patterns have to be differentiated, established, and changed so that interaction is able to move on.

As I have stated before, we all need relationships. Especially minimally responsive patients are in danger to starve on an emotional level – Besides the psychotrauma of the accident isolation and depression can develop. I see a wonderful possibility to work against these difficulties through music therapy. With the work on the ability to build up a relationship the way for the process of sorrow is opened up, which is a very important step in the mental rehabilitation of the minimally responsive patient.

References

American Congress of Rehabilitation Medicine – Position Paper: Recommendations for use of uniform nomenclature pertinent to patients with severe alterations of consciousness. In: Arch Phys Med Rehabil Vol 76, 1995, S. 205-209

Benenzon, R. O.: Einführung in die Musiktherapie – Mit einem Vorwort von Gertrud Orff. Kösel Verlag München 1983

Berger, E.: Die SDKHT in der neurologischen Rehabilitation – Ein Paradigmenwechsel und die Schwierigkeit der Etablierung von Kooperation und Kompetenztransfer. In: Rödler u.a. (Hrsg.): Es gibt keinen Rest – Basale Pädagogik für Menschen mit schwersten Beeinträchtigungen. Luchterhand Verl

Buber, M.: Das Dialogische Prinzip. Lambert Schneider Verlag Heidelberg 1984, 5.Auflage

Gustorff, D.; Hannich H.-J.: Jenseits des Wortes – Musiktherapie mit komatösen Patienten auf der Intensivstation. Verlag Hans Huber Bern u.a. 2000

Jochims, S.: Emotionale Krankheitsverarbeitungsprozesse in der Frühphase erworbener zerebraler Läsionen. Musik-, Tanz- und Kunsttherapie 3, Georg Thieme Verlag Stuttgart 1992, S. 129-136

Jochims, S.: Singend miteinander verbunden sein... – Die Stimme im Zentrum der Therapie bei neurologischen Erkrankungen in der Frühphase. Musiktherapeutische Umschau 11, 1990, S. 127-131

Lipp, B; Schlaegel, W.: "Wege von Anfang an" – Frührehabilitation schwerst hirngeschädigter Patienten. Neckar Verlag Villingen-Schwenningen 1996

Mössler, Karin: Beziehungsaufbau mit minimally responsive Patienten – Musiktherapie in der Frührehabilitation mit Kindern. Unveröffentlichte Diplomarbeit im Kurzstudium Musiktherapie, Universität für Musik und darstellende Kunst Wien 2001.

Petzold, H. (Hrsg.): Die Rolle des Therapeuten und die therapeutische Beziehung. Junfermann Verlag Paderborn 1987, 2. Auflage

O´Dell, M.W.; Riggs, R.V.: Management of the Minimally Responsive Patient. In: Horn, L.J.; Zasler, N.D. (Eds): Medical Rehabilitation of Traumatic Brain Injury. Hanley und Belfus Philadelphia 1996.

Priestley, M.: Analytische Musiktherapie – Vorlesungen am Gemeinschaftskrankenhaus Herdecke. Klett Cotta Verlag Stuttgart 1983

Schumacher, K.: Musiktherapie mit autistischen Kindern – Musik-, Bewegungs- und Sprachspiele zur Integration gestörter Sinneswahrnehmung. Fischer Verlag Stuttgart 1994

Schumacher, K.: Musiktherapie und Säuglingsforschung – Zusammenspiel. Einschätzung der Beziehungsqualität am Beispiel des instrumentalen Ausdrucks eines autistischen Kindes. Peter Lang GmbH Europäischer Verlag der Wissenschaften Frankfurt am Main 2000, 2. Auflage

Stern, D.: Die Lebenserfahrung des Säuglings. Klett Cotta Stuttgart 2000, 7. Auflage, englische Erstausgabe 1985

The topic of this paper is taken from an unpublished diploma thesis, that was passed with distinction, of the music therapy study at the Viennese University of Music and Performing Arts.

MAKS – the musical behaviour scale of expression and communication. A contribution of quantitative research in music therapy

MAKS – eine Skala zur Erfassung musikalischen Ausdrucks- und Kommunikationsverhaltens . Ein Beitrag zur quantitativen Forschung in der Musiktherapie

Dorothee von Moreau

There is a lack of specific and well evaluated instruments for measuring effects of music therapy. Research questions such as the following are required: Do patients in different diagnostic categories differ in their expressive and communicative behaviour? Do they show improvements in these areas after music therapy? And how can we measure improvements in patients, who often are not able to verbalise or reflect their experiences during or after therapy? To date, there are qualitative approaches to describe treatment in music therapy, but relatively few quantitative descriptive inventories exist, which are comprehensive and economic and which fulfil the classical criteria of psychological tests.

The presentation introduces a newly developed 7-point scale for the measurement of expressive and communicative musical behaviour in music therapy (MAKS) (see Moreau 1996). The aim of the scale MAKS is to operationalize nonverbal expressive, behavioural and communicative as well as musical aspects of a music therapy improvisation in a quantitative manner. There are 15 Items for measuring the expressive and further 13 Items for measuring the communicative behaviour of a patient in music therapy.

The items were generated 1. by an expert questioning, 2. by item selection from existing scales plus 3. by personal experience and protocols from music therapy sessions. One pretest by experts was used for modifying certain items and their operationalization. A second pretest by students was used for item reduction and further adaption.
The so developed scale MAKS was tested first by a sample of 52 raters (music therapists and music therapy students with different levels of knowledge and practice) and retested after 4-6 weeks by 32 raters.
For the rating we used video sequences of 20 sec from a first session of music therapy with 12 adolescent patients. The patients had about the same age (16-17 years) but differed in psychiatric psychopathology. So 10 video sequences of

different solo-improvisations on the drum for the rating of the expression-scale, 10 video sequences of duo-improvisations with both, the patient and the therapist on the "Big-Bom" for the rating of the communication-scale were gained.
One rating-session took 3 hours including a short introduction and training of the items and their operationalization and a short break between solo- and duo-sequences.
A highly significant differentiation of the items between the different video-sequences respectively between the different patients were demonstrated by Friedman test. The independence of the items, evaluated by Kendall's tau = 0.3, is good and even was improved in the retest. A varimax-rotated factor analysis confirmed the hypothetic structure of the scale by the factors "flexibility", "form", "power", "vitality" and "emotion" for the expression-scale and the factors "contact" and "autonomy" for the communication-scale over the two measuring dates.

The inter-rater-reliability (Kendall's tau) ranged between 0.5 to 0.7 and partly improved in the retest. The retest-reliability (using +/-1 differences as a more tolerant value) showed a high correspondence between first and second rating.

We assume, that a more intense and specific rater-training might improve results in inter-rater- and retest-reliability. Further studies with different diagnostic groups might demonstrate the clinical validity of the scale. Recent studies on schizophrenic patients showed (see Plum 1997, Isermann 2001) that MAKS is a good instrument for measuring psychopathological improvements after music therapy.

References

Isermann H. (2001): Einzelfalluntersuchung einer Gruppenmusiktherapie mit schizophrenen Patienten. Unveröffentlichte Abschlussarbeit Hochschule Enschede, NL

Moreau D. von (1996): Entwicklung und Evaluation eines Beschreibungssystems (MAKS) zum Ausdrucks und Kommunikationsverhalten in der Musiktherapie . Unveröffentlichte Diplom-Arbeit an der Universität Würzburg

Plum F.J., Lodemann E., Finkbeiner T., Bender S., Gastpar M. (1998): Entwicklung des Kontaktverhaltens, des improvisatorischen Spielausdrucks und der Psychopathologie im Verlauf einer Gruppen-Musiktherapie mit schizophrenen PatientInnen. In: LVR in Kooperation mit DGMT (Hg.): Hast Du Töne – Musik und Therapie im Rheinland. Köln

Integrative Music Therapy

Integrative Musiktherapie

Ranka Radulović

Integrative Music Therapy is a new psychotherapeutic technique of psychotherapy with children which is based on techniques of active music therapy as well as on elements of analytical group psychotherapy, cognitive-behavioural psychotherapy, art and dance therapy and of psychodrama.

The term „integrative" also points to the position of integrative therapeutic aims and shows the results of the integrative term in psychiatry, psychotherapy and rehabilitation. This technique was created at the school for psychotherapy in Belgrad and is indicated for children with psychotic and non-psychotic disorders, cognitive disorders, speech and visual disorders, auditory handicap, psychomotoric disorders and problems of social behaviour. It is also indicated for all those cases of illness and developmental disturbances where it is difficult to use verbal psychotherapeutic techniques. It also can be applied to stimulation and the observation of the development of healthy children.

Integrative Music Therapy offers an original methodology and tools for a prospective discussion of its results concerning the development of motor control, of hearing and concentration, as well as the development of self-concept and awareness of the others, of social skills and of fantasmatic capacity. This technique supports the problem solving of actual intrapsychic problems, it defines special characteristics of the settings with various patients, instruments and additional equipment. It also gives clear structures for individual and group seances (called „games"), which take 60 minutes once a week. Integrative Music Therapy defines elements and aims of other psychotherapeutic techniques within the scope of a music therapy seance. All events during a seance are understood analytically and an analytical record is kept. Interventions mostly happen on a cognitiv-behavioural level, they are verbal or non-verbal and they also include psychomotoric reduction and speech exercises.

This study was published within a dissertation in 2001 at the university in Belgrad. It is a perspective and comparative statistic study about the application of

Integrative Music Therapy to children with cerebral palsy at the Beograd Special Hospital of Cerebral Palsy and Development Neurology.

Two groups, each had 30 people, were tested during sixteen weeks. One group of patients had Integrative Music Therapy, the other one was a control group. The patients were lightly mentally handicaped and their average age was ten years.

We found out that Integrative Music Therapy contributes to a psychomotoric, emotional and social stabilisation to children with cerebral paralysis. According to the statistic analysis the group who had Integrative Music Therapy presented a significantly better progress than the control group.

The most significant results and progresses appeared on the assessment of bodily completeness (The Assessment Scale of Bodily Completeness from Stevanovic): A cluster analysis leaded to the building of so-called "levels of priority" concerning the single organs in their self structure. Also the process of "self integration" became obvious during the therapeutical process which can be seen as a contribution to the theory of Melanie Klein.

The best results were shown by the assessment tests of the emotional and social status (Questionnaire for Assessment of Behaviour and Communication, Ganzberg) and by the stimulation of hearing and concentration (Test of Hearing, Radulovic). This indicates also the role of the Integrative Music Therapy as a psychiatric technique.

There were no statistically significant progresses in practical gnostic organisation (Test of Imitation of Movements from Berges-Lenzin), in assessment of experiences and in sense of time (Three Tests of Rhythm form Stambak). Maybe these results can be conditioned by limitations of time, of technique or observation tools.

The principles of group theraypy are also applicable to a patient group with cerebral palsy and it was possible to observe this also in the group where Integrative Music Therapy was offered.

After a strong selection of patients concerning the principles of a group setting, a group-matrice developed: There was a net of transference, important interactions on the group level, between the single members and the therapist. All the typical group phenomena were observed and described: the phenomenon of condenser, resonance, examination, of sacrifical lamb etc.,

as well as analytical phenomena: interventions, mechanisms of defence, resistance, transference and counter transference at the verbal and non verbal level.

This technique offers two instruments of observation:

1. The Scale of Social Skills (Radulovic, R.) made possible:

- a descriptive observation of single patients in their development of social skills (control of aggressivity, readiness of cooperation, initiative, ability to communication and common sense), a comparison and interpretation of their social function on the group level;

- a verification of specific group dynamical phases within this category of patients - the inital phase, the phase of social isolation (until the 5th week), the phase of coalition (from the 5th to the 12th week), the final phase or the phase of group cohesion

2. the Hearing Test (Radulovic, R.) is able to give indications and descriptive observations around effects of Integrative Music Therapy on hearing and development of concentration. It can be seen as a prove of Benenzon´s theory of the identity of tones.

The methodological work about the technique of Integrative Music Therapy achieves a large spectrum of therapeutical effects. The clear structure of the seances does not limitate dynamics and flexibility during the therapeutical process. Clear aims of therapy and conditions of time lead to a description of results, a comprehension of psychodynamics of this patient category.

Training research: music therapy self-experience and the perception of specific curative factors

Ausbildungsforschung: Musiktherapeutische Selbsterfahrung und Wahrnehmung spezifischer Wirkfaktoren

Dorothea Oberegelsbacher

Introduction

Many, but not all, music therapy schools, provide self-experience within their curricula. This experience aims to form personality, build self-awareness and stimulate perception about the specific working style and techniques of the particular music therapy approach. These objectives are mediated holistically within music therapy relationships which are both unique and unrepeatable. How does the music therapy student perceive the general and specific curative factors? Are any of these factors recalled especially by the student?

Many years' experience in leading self-experience groups with music therapy students in Italy led to several impressive moments and feedbacks: One participant tried to express his name with sound and the group shared verbally with him afterwards its associations and images. It turned out that he had hated his name as a child, as his parents had argued over his name when he was born and chose to name him after his grandfather – following tradition. Yet another student told me a year after the group had ended that she had never been able to endure silence. But now it changed, silence had lost its threatening quality, as she had often experienced in the group that unpleasant silence within one's self could transform into something that made sense, if one waited in trust. There were other experiences in which recent political events or traumata from natural catastrophes were worked through with music therapy. I will never forget the heart-stirring, desperate group improvisation in connection with the mafia murder of Judge Falcone and the immense solidarity which emerged through the music.

Music therapeutic identity needs for its development a music therapeutical process. Some essential *contents from music therapeutic self-experience*, according to Elena Fitzthum, Teaching Therapist for the Vienna Music Therapy Training, are as follows: experiencing the therapeutic relationship; developing awareness of and reflection on one's own life history; getting to know the (music-)

therapeutic tools; laying the foundation for a future identity as music therapist. (Fitzthum, 1997, p. 241 f. from Frühmann, 1996).

Music therapy training research deals with the development of music therapy competence and serves quality assurance. Nevertheless, this is a nearly invisible area on the periphery. Given the consideration that in the psychotherapeutic community the training research is a step-child among the publications, that can certainly be claimed to be true for music therapy as well.

Four perspectives of training research, based on Anton Laireiter, an Austrian psychotherapy researcher at the University of Salzburg, could in the opinion of the author also pertain to music therapy: 1)Training-effect Research 2) Training-process Research 3) Quality assurance 4) Evaluative and descriptive training research.

Here it is also true that the field is very heterogenous and an urgency for research is missing. For example, The 3-column-model in psychoanalytic training has been in effect since the 1920s: theory/method – supervision – own therapy/self-experience. The goals are considered to be: professional competence, autonomy, sense of responsibility and professionalism, effectiveness (A. Laireiter, 2001).

The Pilot Study

This pilot study is based on a questionnaire developed in a post-treatment retrospective survey with psychosomatic patients after a period of intensive psychotherapy (Mayr, 2001), including group music therapy in the tradition of the Viennese School of Music Therapy. The questionnaire focused on non-specific curative factors (Strupp, 1964, 1978); on 11 group factors (Yalom, 1968, 1996) and specific music therapeutic curative factors (Oberegelsbacher, 1997; Strobel, 1990): e.g. nonverbal communication, symbolic expression, catharsis, nonverbal working through, acting with free improvisation, aesthetic function, development of prelogical and logical structures etc. The questionnaire 'Wirkfaktoren Musiktherapie WIMU' has a social data part and a power factor effect part. This 2nd part has about 60 items and attempts to identify the power factors of music therapy. All of the items included are to be answered on a 5-point scale, with varying degrees from “absolutely right” to “absolutely wrong”. The term “therapist” was altered into “music therapist”. Some typical items include: "Through music therapy I was able to see past feelings in a different light./ I have beome more imaginative, curious and courageous since the music therapy./ With music therapy I was able to try out and practice new behaviors besides my old habits./ When I played various instruments I was able to act without first having to

think it through./ The music helped me experience a strong sense of release /The music in the music therapy triggered off physical sensations etc

The analysis of the data, using descritpive statistics and factor analysis, showed a `high-loading´ specific curative factor "Expression, Representation and Communication with Music", two non-specific curative factors and two other specific factors (Danner, Oberegelsbacher, 2001).

The same questionnaire and kind of intervention were applied with students (N=80) attending a four-year music therapy course of study in Assisi, Italy. They took part in music therapy experiential groups (daily two-hour sessions) during their two-week residential schools. The results of this study can be presented and discussed including the relevance of shorter periods of experiential work.

Description of the Test Population

73 of 80 distributed questionnaires were answered (anonymously), which corresponds to a very high return rate (91%). 68,5% of the participants are female. The average age was of 32 years. The achieved level of schooling was: High school, doctorate degree, music diploma, short-term study program etc.
Their vocations are: music teacher, musician, educator, psychologist, physician, therapist (paramedical), teacher, social worker and other. It was set out to be shown that parenthood (or non-parenthood) as well as the length of time since the seminar have no effect on any of the investigated areas. All of the other variables were expected to show some effect

Results of Factor Analysis

(8 components, a rotation according to the Varimax-Method was implemented).
From all of the suspected specific power factors, a total of three showed tendencies, based on the calculations:
"Working out of problems with music therapy, music therapeutic working out" / "Expression, presentation und communication via music"/ "Effect of music and music therapy"/
In addition to these specific power factors, several unspecific power factors were extracted: "Appreciative attitude of the music therapist" / "Function of the group itself" / "Qualifying and comparison with the group" etc.

Comparison of the clinical group with the student group

The comparison (t-test and u tests) showed that factors from the first pilot project on the clinical group (5-component-solution) are partly replicable in this second pilot project with students. Three factors were able to be reproduced. They are: the

specific factor "Expression, presentation and communication via music" (in the student group in third place, in the patient group first place); the non-specific factor "Appreciative attitude of the music therapist" (in the student group second place, in the patient group fifth place), as well as the nonspecific factor "Function of the group itself" (for students fourth place, for patients second place). In addition, it is noticeable that the dimension of activity arises in both groups, despite their varying appearance: among the students it is within factor VII (called "Activity vs. Passivity") and among the patients within factor III (called "Active offer of musical interaction with the music therapist"). This is a typical phenomenon of the Viennese School of Music Therapy.

At the end of the questionnaire the participants were asked to describe in their own words "impressions, memories or concerns" regarding music therapy. These statements were very emotionally charged in both pilot projects. Students offer mainly positive comments regarding the value of this group experience: intensive community experience, self-realization and relationship to music are frequently mentioned. It is remarkable how many comments are based on style of leadership and reflection on the form of intervention: an indication that awareness of the future therapeutic role is already present. Another strong point is the differentiated and positively-toned observation of the music therapist, who is explicitly experienced as a positive figure of identification and is described as a role-model for the future. There are also two depreciatory comments which could be indications of unsolved negative transference

Further (statistically significant) main results:

1) There is a gender-related difference in factor 3 "Expression, presentation and communication through music". Men reject the possibility for expression, presentation and communication through music significantly stronger than women (Are men more sceptical of communication which does not rely on words?)

2) One item called "In the shared music, negative and positive were able to resound simultaneously and somehow it made sense" was agreed to by significantly more women than men. (Do women have more tolerance for ambiguity on the nonverbal level? Are they better at integrating ambivalent aspects?)

3) There is also a vocation-based difference in factor 4 (Function of the group itself). Educators and teachers reject the function of the group itself significantly stronger and all other vocational groups reject it less (Are educators and teachers

made more insecure or more stressed in a process-oriented group interaction as a result of their obligation to the curricula?)

Conclusion

This investigation successfully employed data-reducing methods to identify and confirm initial trends regarding assumed power factors of music therapy as based on the first pilot study. .It is astounding that it was possible to isolate a factor in the first position which could be identified as being specifically music therapeutic and very work-related. This goes to show that the students clearly grasp the uniqueness of the music medium as a therapeutic means for work and expression. They are also aware of the therapeutic relationship and the group itself. This corroborates what has been accepted in the field for quite some time: music as an additional medium for expression and communication is an efficient and meaningful enrichment to the spectrum of psychotherapeutic treatment – as compared to a purely verbal approach – and can also be successfully transmitted in the training process.

References

Danner, B., Oberegelsbacher D. (2001). Spezifische und unspezifische Wirkfaktoren der Musiktherapie – Katamnestische Erhebung an psychosomatischen Patienten einer psychiatrischen Klinik. *Nervenheilkunde*, Jg. 20 (434-441) oder Heft 8 (30-40)

Fitzthum, E. (1998). Einzel-Lehrmusiktherapie im institutionellen Rahmen. In E. Fitzthum, D. Oberegelsbacher, D. Storz (Hrsg.), Wiener Beiträge zur Musiktherapie, Bd 1. (S. 193-216). Wien: Edition Praesens.

Laireiter A. (2001). Überblick über den Stand der Ausbildungsforschung. *Unpublished keynote paper*: Der Stellenwert der Psychotherapieforschung für die Aus-, Fort- und Weiterbildung von Psychotherapeut/inn/en. Conference of the Coordinating Office for Psychotherapy Research and the Austrian Federal Association of Psychotherapy ÖBVP, 22.-25. Nov. 2001 in Innsbruck, Ancient University, 11.23.2001

Mayr B. (2001). Spezifische und unspezifische Wirkfaktoren von Musiktherapie aus der Sicht psychosomatischer Patienten. Unpublished diploma thesis of Kurzstudium Musiktherapie at Vienna University of Music and Performing Arts. Vienna

Oberegelsbacher D. (1997). Musiktherapeutisches Improvisieren als Mittel der Verdeutlichung in der Psychotherapie. In E.Fitzthum, D. Oberegelsbacher, D. Storz (Hrsg.), Wiener Beiträge zur Musiktherapie, Bd 1. Weltkongresse Wien Hamburg 1996 (S.42-66). Wien: Edition Praesens.

Oberegelsbacher D. (2001). Zur Rezeption unspezifischer und spezifischer Wirkfaktoren von Musiktherapie in der Selbsterfahrung. Abstracts aus Symposium 6: Psychotherapieevaluation, Tagung der Koordinationsstelle für Psychotherapieforschung und

des Österr. Bundesverbandes für Psychotherapie 22./25. Nov.2001 in Innsbruck, *Psychologische Medizin* 12. Jg., Heft 3(33-34)

Schmölz A. Selbsterfahrung im Rahmen der Musiktherapie. In: Psychotherapie im Wandel. Festschrift zum 20. Internationalen Seminar für Psychotherapie, Bad Gleichenberg. Pieringer W, Egger J. (Hrsg.). Wien: Universitätsverlag 1991; 129-133.

Strobel W. Von der Musiktherapie zur Musikpsychotherapie. Musiktherapeutische Musiktherapeutische Umschau 1990; 11: 313-338.

Strupp HH, Wallach MS, Wogan M. (1964). Psychotherapy experience in retrospect: Questionaire survey of former patients and their therapists. (pp. 558) In: *Psychological Monographs general and applied.* Kimble GA.

Yalom ID, Tinklenberg J, Gilula M (1968).Curative Factors in Group Therapy. *Unpublished study,* Department of Psychiatry, Stanford University. Stanford.

Yalom ID. Theorie und Praxis der Gruppenpsychotherapie (dt. Neuausg., 4., völlig überarb. und erw. Aufl.). München: Pfeiffer 1996.

Wednesday

17

Music Therapy Treatment Within a Multimodal Outpatient Treatment Concept

exemplified by the possibilities and limits of the procedure in treating an affective anxiety previously expressed as a psychosomatic disorder, taking account of transference enactment and genogram work

Möglichkeiten und Grenzen einer musiktherapeutischen Behandlung eines bisher psychosomatisch gebundenen Angstaffektes (Einzelfalldarstellung)

Barbara Dettmer

Improvisation in music therapy gives rise to affective experience which resonates in the therapeutic relationship and provides material for change. Findings and assumptions in the neurosciences indicate that this is significant because it means access is gained to memory material. The lack of response which requires change can thus be stimulated and the way to new cortical and subcortical responses can be cleared.

An example of treatment with its particularities illustrates changes and how these are initiated. A brief description of symptoms, anamnesis, therapy indication, treatment plan and catamnesis is followed by emphasis on the course of the therapy, with attention to improvisation as well as extramusical work and understanding of these.

The presentation follows the phases of treatment:

1. An improvisation and its consequences. Continuation of therapeutic communication in the enactment, and understanding this.
2. Loosening of control and deepening of the therapeutic relationship, supported by genogram work.
3. Introduced by "guardian angel music", work on the central anxiety affect.
4. Renewed occurrence of misunderstandings, and shaping of farewell.

Emphases are:

- sparse music in spite of marked musical interest and ability
- divergent expectations and divergent experience in the improvisations
- high affective tension
- enactments with the secondary family in an area close to the therapy, and somatic events as extramusical expression of affect and as extramusical communication
- genogram work as a means of controlling and successfully regulating the course of the therapy and the therapeutic relationship
- beginnings of affect integration

Topics for discussion:

Proposal to take account of the psyche's inadequacy in coping with conflicts that remain unconscious, and to supplement the affect engulfment that may result from musical communication by treatment techniques which are less experience-based.

Call to look beyond improvisation, which is an elaborated method, and make room for the enactment of memories; to increase understanding of extramusical events, and to focus treatment technique more precisely.

References:

Dettmer, B. (1999): Zum Verständnis und zur Einleitung der Veränderung innerer Strukturen. Systemische Gedanken zur musiktherapeutischen Improvisation. Musiktherapeutische Umschau 20, 878-893

Roth, G. (2001): Wie macht das Gehirn die Seele. Vortrag Lindauer Therapietage.

Streeck, U. (Hg) (2000): Erinnern, Agieren und Inszenieren. Enactment und szenische Darstellungen im therapeutischen Prozess. Göttingen. Vandenhoek & Ruprecht

v. Schlippe, A./Schweitzer,J. (1996) Repräsentationsformen für Systeminformationen. Lehrbuch der systemischen Therapie und Beratung. Göttingen. Vandenhoek & Ruprecht, 130-136

Zeul, M. (1999): Zwei Sprachen einer Körperphantasie. Zur Dynamik der Gegenübertragung. Psyche 53, 1015-1041

Specific and non-specific factors of music-therapy seen from the point of view of a group of psychosomatic patients

Spezifische und unspezifische Wirkfaktoren von Musiktherapie aus der Sicht einer psychosomatischen Patientengruppe

Barbara Mayr

The specialist literature reduces the impact of different forms of psychotherapy on specific factors, which can be divided into two groups: into non-specific and specific factors. Accordingly detailed studies and investigations already exist in research literature (e.g.: Bozok & Bühler, 1988; Czogalik 1990; Czogalik & Enke, 1997; Kächele 1988; Senf 1988; Strupp & Hadley, 1979).The lecture deals with music therapy concerning specific and non-specific factors.

First of all there are definitions of music-therapy and psychotherapy, followed by already investigated specific and non-specific factors of different ways of psychotherapy. The next step is a look at the present state of the research of music-therapeutical factors. To charge these factors, a questionnaire was developed within the frame of a dissertation in music-therapy at the Viennese University of Music and Representative Art. It was given to psychosomatic patients at a psychiatric clinic within a catamnestic research. The investigated patients were all in-patient for an eight-week psychotherapy turn in-between the last five years at the psychosomatic department of the University Clinic of Psychiatry at the Viennese AKH. They took part in different forms of therapy and also in music-therapy following the tradition of the Viennese school for music-therapy (psychdynamically and individually psychologically orientated).

The developed questionnaire includes a part about social data, questions about non-specific factors, (based on the research group of Kächele, Univ. Ulm quoted after Strupp, 1985), questions about group-factors (after Yalom, 1996) and questions about specific music-therapeutical factors (orientated on Strobel, 1990, Oberegelsbacher, 1997). The evaluation of the ascertained data happened especially through the factor analysis besides certain descriptive statistical explanations.

The results show that especially three specific factors are responsible for the impact of the described forms of music-therapy, beside two non-specific factors (group-impact, behaviour of the music therapist). These three specific factors are "expression, description and communication by means of music", "active musical relationship of the music therapist" and "music-therapeutical work and possibility for music-therapeutical transformation". That is the reason why the specific factors of music-therapy are given a special significance. Empirical indications on the characteristics of this form of therapy are provided by the isolation of specific music-therapeutical contributions and they are therefore a step forward regarding the admission of music-therapy as an autonomous form of psychotherapy.

The topic of this paper is taken from an unpublished diploma thesis, that was passed with distinction, of the music therapy study at the Viennese University of Music and Performing Arts.

Music therapy with stuttering adults

Musiktherapie mit stotternden Erwachsenen

Sophie Wiedner

Stuttering can be defined as an impairment of the flow of speech that occurs in dependence of the current speaking situation and increases with emotional participation. The following characteristics can be observed: physically, speaking symptoms restrain the flow of speech. Postures, prolongations and repetitions of utterances may occur. These are often combined with secondary physical reactions (such as states of struggle and excitement, movements etc.). The disorder manifests itself psychologically through fears (e.g. concerning the speaking situation). In addition to that, inhibitions of aggressions, feelings of inferiority, avoidance strategies and further psychic reactions are often reported. The fact that the occurrence of symptoms and their intensity are bound to social situations point out that stuttering represents a disorder of social contacts.

The consensus is that the stuttering individual is affected in all conditions of life. Still, there are various theories of this impairment, and these lead anew to different therapeutic approaches. The following theories predominate:

Constitutional theories assume organic causes (e.g. a neuromuscular impairment of co-ordination). According to these there are attempts of "organic" influencing. In contrast, specialists of psychodynamic theories consider stuttering as expression of non-dissolved, instinctive conflicts during infancy and explain these by unfavourable familiar conditions. Both psychoanalytic and individual psychological concepts postulate ambivalences between conflicting impulses. The therapy consists of attempts to bring out and work up the psychic conflicts and to provoke a "psychic readjustment". However, behaviouristic theories regard stuttering as falsely adjusted or learned behaviour, for instance as a conditioned result of emotional excitement. Correspondingly, behaviouristic therapeutical techniques are employed (such as systematic desensitization, alternative/new conditioning etc.). The most current stuttering approaches in this connection are the "modification of stuttering" (which aims at effortless, "fluid" stuttering) and the "fluency shaping" approach (which aims at stutterless speech). Since most experts today assume a multiplicity of causing factors, combinations of different therapeutical methods are used.

Relevant for the subject in question primarily are treatment approaches that integrate musical parameters. Three directions can be determined: several speech therapists combine orthophonological treatment methods with musical parameters by utilizing the relaxing effect of music or by using its specific components (such as rhythm, melody or dynamics) as accompanying and rhythmic aids for speech. Specialists of rhythmics turn to account the interrelation between music, speech and movement in order to diminish the stuttering symptoms. Finally, articles that document music therapy with stuttering adults exist sporadically. These give an account of positive changes of the stuttering symptoms especially by playing music and improvising actively.

Which arguments seem to justify the indication of music therapy with stuttering adults? The prerequisite is that the concerned persons are strongly afflicted with their secondary psychic and social symptomatology. As stuttering also represents a rhythmic impediment of speech and body, a therapeutic aid of rhythmic elements seems promising. Moreover, important parallels between speech and music (such as common elements, similar forms of emotional expression etc.) have been found.

Within the scope of the thesis, the speaker makes the assertion that music therapy is able to increase the life quality of stuttering adults in physical, psychological and social domains.

This hypothesis was empirically verified by the analysis of a 20-hour group music therapy project that the speaker conducted with six persons from September 2000 to April 2001.

Crucial points of this therapy were the investigation of the actual condition, the realization of own needs and the analysis of personality aspects, emotions and behaviour patterns. Particular emphasis was laid on stuttering and the subjects´ coping abilities. Thus, the clients occupied themselves with engendering factors of stuttering, stutter-related emotions, fears and ambivalences, dealt with social difficulties or drew parallels between their mode of playing music and their everyday behaviour. Soon it became apparent that each client concentrated on individual points of emphasis (e.g. “getting loud”, relaxation, release of cognitive control, discovery of own vivacity, ...).

A brief table of the most crucial points:

	Physical domains:	**Psychical domains:**	**Social domains:**	**Playing behaviour:**	**Ressources:**
Diagnostic Observations:	individual degree of symptoms secondary reactions in all cases	urge for harmony and release ↔ on the other side cathartic needs emotional insecurity and avoidance behaviour, cognitive control stress of performance ambivalences <u>Pre-tests:</u> rather elevated anxiousness, non-uniform tendencies of aggressiveness; mostly non significant	social anxiety ⇒ passivity, retention, adaptation attitude of consumption difficulties in contact indirect equivalents of aggressiveness avoidance of confrontation, conflicts, commitment justification, defensive	soft play moderate tempo little variation unsteadiness lack of social contacts long duration of play opposed themes drop of theme during play wake effect	mutual comprehension urge of expression ability to act in a conscious way curiosity motivation for change patience and perseverance
Observed changes/ developments	Release from tension	Increased joy of self-expression, increased self-confidence Release ⇒ decrease in performance stress, emotional insecurity and control Growth of reflection abilities and authenticity <u>Post-tests:</u> decreased tendencies of anxiety, different development of aggressiveness	inhibition reduction, increased conflict willingness increased group contact raising of perceptive faculties subsiding of depreciation	augmented variety and complexity increased liquidity, release individual presence, self-assertiveness, initiative and self-delimitation keen on vocal experimenting, daring increased contact intensity, adjustment	

Two of the specific therapeutical challenges with these clients consisted in time elements (duration of reflections, referring to utterances, termination of sessions, ...) as well as the therapists adjustment to deviating aspects of communication (elongated visual contact, function of own playing and verbal behaviour).

Which were the **findings** gained by the therapist in the course of her investigations?

The previous established hypothesis that music therapy contributes to an increase in quality of life in stuttering adults could be confirmed in all of the three examined domains (body, psyche, social behaviour), and that by means of following statements:

Music therapy is able to positively influence the physical symptomatic of stuttering adults.

- The musical medium is in the position to support the **development of a healthy regulation of agitation and activation**. Thus, relaxing receptive sounds occasionally lead to a decrease of the stuttering rate and intensity as well as to more organic breathing. In contrast, active improvisation can be employed as an energy vent for the dissolving of tensions and blockings.
- **Further effects of specific therapeutical techniques** are the sensitization for perception and the establishment of a more positive body relation (e.g. concerning the own voice). In addition, the specialized literature states a stimulation on central nervous levels, the opening of more fluid time patterns, a stabilisation of movement co-ordination, the strengthening of respiration and a positive influence on voice.

Music therapy offers help to stuttering adults with their psychic difficulties.

- Different aspects facilitate an **emotional access**:
- Both musical reception and action induce and influence emotions. In addition, music offers a less encumbered possibility of expression to the clients than speech. The inviting nature of the instruments, the absence of stress and the orientation on experiencing within the therapeutic context not only wakes the participants´ joy of self-expressing, but also supports a (re-)connection to one´s emotion. Formerly negatively charged means of communication, such as the own voice, can be experienced as pleasing, for instance in vocal improvisations. Each client obtains enough time and individual liberty to develop at his own speed and to get in touch with himself. The mediating and transition-forming nature of

music in the active improvisation serves as a means of transportation to make audible inexpressible feelings and to express conflicting emotions without the fear of negative consequences.

- Following aspects serve for the **strengthening of self-confidence and self-assurance**:
- The client experiences a sense of achievement within the field of expression. The therapeutic absence of stress and thematically adapted improvisations (with practising, confronting tasks) contribute to the removal of social fears. The expressive spectrum and the communicative abilities can be extended within the therapeutic interaction – especially by non-verbal elements –, and vocal improvisations can improve vocal confidence and familiarity.
- Music therapy is conducive to the **understanding of psychic relations**:
- Music allows such insight not only because of its associative effects, but also by offering new ways of initiating processes of realization and change. The clients may draw parallels between playing and everyday behaviour, gain new recognitions and views and – especially in role-playing – come to perceptional, attitudinal and behavioural changes. The fact that conflicts can be traced out on a "harmless" (since musical) level and pertinent solutions can be tested facilitates in the confrontation of these problems. Finally, reflecting the own behaviour within a group context often leads to growing authenticity and honesty towards oneself and others.
- **Further developments** in psychic domains are the following:
- Musical activity stimulates the participants´ creativity, vivacity and autonomy. The possibility of acting out pent-up affects in a musical-cathartic way allows the reduction of inner stress, tensions and blockings and may resolve conflicting tendencies. The latter contributes to emotional stabilization. Moreover, musical activity offers a vent for the expressive backlog of many stutterers.

Music therapy may introduce social alterations in stuttering adults.

- Music therapy contributes to a **widening of social competencies**:
- The possibility to renounce speech supplies a more fearless starting position for communication and makes this possible. By omission of speech, interaction takes place on a personal level, which leads to new experiences and to a widening of the non-verbal spectrum of

communication. With thematically specific improvisations (such as "self-assertion", musical "disputes" a.s.o.) the clients beyond that attain growing communication abilities, security and flexibility. This sets free perceptional capacities towards other persons and intensifies necessaries of contact. One special advantage of the mediating nature of music is that the clients may approach more direct and complex communicative situations at their own speed. This has the power to release tensions and inhibitions due to social fears and to support the development of self-regulation of individual contact desires. In this connection, role plays offer a precious field of exercise for the building-up of self-confidence and social abilities. The thereby possible enhancement of conflict abilities, frustration tolerance and the likes, offers the basis for later changes in speech domains.

- All these aspects contribute to a new sense of well-being and therewith an **increasing quality of life in social contexts**. This eases the individual to experience himself as an integrated and full member of society.

- Which are the **specific advantages with a group music therapy setting**?

- On the one hand, the group offers a real context in which ways of acting can be tried out. At the same time, and due to the similarity of symptoms, it offers a shelter in which the clients can stutter more easily and fearlessly than usual. In addition, each participant may compare how he perceives himself to how he is perceived by others at the aid of feedback. If necessary, this allows him to revise unrealistic attitudes or negative perceptions of himself. Within the group, communication abilities may be acquired, practised, consolidated and tested. Besides, mutual animating, encouraging and learning from and with others as well as the profiting by the model of fellows push ahead the development of a group process. Contacts are expanded, and the participants may make experiments on the exploration of their individual position in social contexts. All this finally leads to increased confidence and a sense of togetherness with the group.

In the speakers opinion, following final conclusions ensue for music therapy:

Further discussions concerning the subject in question appear necessary and indicated. Profound research is required. An important, still missing point, is an exact boundary to the field of speech therapy. It also should be reflected on how stuttering persons could be made aware of the possibility of music therapy.

As an impulse for future research, the speaker suggests several courses: On the one hand, it would be important to intensively deal with the significance of voice, its employment and its possible function in music therapy with stutterers. In addition, possibilities and functions of rhythm should be established and scrutinized in dependence on the specific clientship. It should also be considered whether the therapeutic participation of close persons may be found meaningful, for instance in form of family or couple therapy. Finally, it would be important to compare the therapeutic priorities in music therapy with stuttering adults to those of stuttering children and to extricate distinctive characteristics.

The topic of this paper is taken from an unpublished diploma thesis, that was passed with distinction, of the music therapy study at the Viennese University of Music and Performing Arts.

Spaces between Speech and Music. Reflections on the phenomenon "silence" in music therapy

Räume zwischen Sprache und Musik. Überlegungen zum Phänomen "Stille" in der Musiktherapie

Monika Lagler

As music therapists we mostly use two media of communication: the nonverbal level of music, of sound at all and the level of our usual, verbal speech. The occurence of silence within these two levels of communication is a indispensable appearance, but nevertheless responsible dealings with silence often mean a special challenge. In the speaker's opinion it is every music therapist's responsibility to open silence to reflexive contemplation and make it therapeutically feasible.

Some basic reflections on the term „silence":

- (concerning this context) total, absolute silence does not exist – silence is always a *relative* one.
- Silence always moves on a continuum between two polarities: between external, acoustic condition and internal feeling; between objectivity and subjectivity; between quantitative and qualitative factors.
- Silence can be understood as *term of feeling*, as an individually different experienced state that moves between external conditions, which are accepted as "silence" by the individuum on the one hand, and internal, subjective factors on the other hand.
- Silence can be described as an *experience of senses* – as a counterpole to noise it leads to internalization (maybe spiritualization) of the individual.
- *Quietness* can be understood as the *bodily* aspect of silence – motionlessness as a countermove to action and activity.
- *Silence (as non-speaking)* is the *linguistic* aspect of silence. It is a contextual, dialogical, communicative phenomenon and can only be described within a theory of communicative acting.

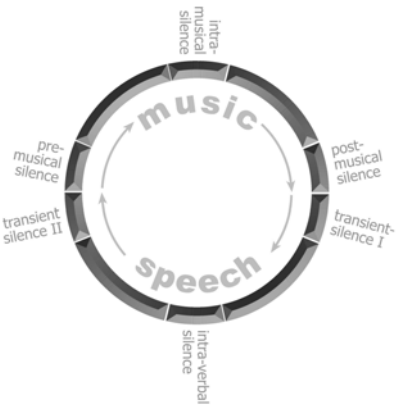
Silence in music:

As in verbal language, silence in music has also an existential meaning – without silence there cannot be any music. *Pauses* can have totally different meanings, depending on the tension of what happened before. The pause has two relational directions: the past, that makes the function and organisational value of silence understandable, and the future, to which silence connects itself. Silence can also be the fertile soil, from which music can arise, from which music can contrast and get discernible. Therefore, sound and silence form two equal poles of a continuum, that permanently keep reciprocally related to each other.

Silence in music therapy:

The speaker's focus is, that silence creates space for the patient to support creative development.

A "*music therapeutical circular model of silence*" (Lagler, 2001) topologically describes 6 possibilities of the occurrence of silence within the alternation of verbal and musical language.



pict. 1 "music therapeutical circular model of silence" (Lagler, 2001)

- *Pre-musical silence* is the silence occuring before the first sound of a musical happening. It is a silence of backpedalling, of orientation to oneself. In case of forthcoming improvisation, attention gets directed to the process, that has to be coped. Own impulses and needs are tracked down, perceived and brought into movement. Pre-musical silence is a silence of concentration, of increased vigilance and attention. It is

important, that silence gets time to end itself, instead of being interrupted before music begins.

- *Intra-musical silence* is the silence within still occurring musical happening. It can be compared to a pause, but it rather corresponds to the spontaneous nature of music therapeutical improvisations than the pause in composed music. Intra-musical silence occurs within numerous music therapeutical games, and it plays an important role for structuring the music.
- *Post-musical silence* is the silence after the fading away of music. It is full of the tonal experience, therefore it also belongs to music. Post-musical silence arises from the immediate preceding tonal happening, therefore its experience and emotional content is connected to the tonal happening's variety very closely.
- *Transient silence I* begins, when the 'being state' of silence turns into the preparation of the experience's verbalization. It builds a bridge between the nonverbal level of music and the verbal level. Cognitive processes start; the music's analogous process of experience should be left to get into the digitally dominated area of verbal speech (the author follows P. Watzlawick's theory of communication). It is a "buffer zone" that allows the nonverbal experience's translation into a communicatable form.
- *Intra-verbal silence* is the silence within conversation, within verbal happening, mainly silence in its acting/active sense, but also in its sense of a 'beeing state'. Some possible qualities: aggression and resistance; frustration, hurt, separatedness; consternation; retreat after contact; silence, that creates space to develop the initiative of one's own or make decicions.
- *Transient silence II* means the time between a verbal happening and the turning to another happening at the musical level. It builds a bridge from the verbal area of communication into the musical area. It may be a silence of making decisions; feelings of uncertainty, inhibition and helplessness may occur as well as resistance and disapproval. The patient's regressive tendencies may turn out. In case of an attempt to get to musical expression by a structured playing offer, attention is directed to the process that has to be coped. New instruments are chosen, the atmosphere changes. Then the silence is a concentrated one, a silence of internal listening. Tension increases and silence may go over to the stage of *pre-musical silence* – the circle gets closed.

The experience of silence in music therapy can be discribed in different levels on which the therapist and the patient move. For the therapist it's a way of the examination of silence, of deepening his dealing with silence and opening silence to creative use.

I) Silence can be described or circumscribed with verbal terms (internal/external, subjective/objective, quantitative/qualitative; silence as non speaking, quiet, pause; etc.)

II) Therapeutical use of silence requires to leave the purely descriptive level. The focus should be directed to the therapeutical relationship. *Against* what is this silence? Which resistances could it come from? Or: *For* what is the silence? What are the deficites of the patient that need regression got going due to silence? This level of therapeutical dealing with silence makes sensitive for symbolical meanings of the experience of silence – silence in therapy can often be a reference to lucky or failed times of silence in the pre-verbal experience of the former child. The therapist can analyse, can reflect in a verbally-linguistic way. However the patient's area does not have speech or words yet. Silence can be used for symbiotically experience as well as space, in which the patient can be aware himself separatly from the therapist.

III) Another level of the experience of silence gets opened in that moments in therapy, when the incomprehensible, the inapprehensible, the unutterable and unspeakable happens – moments of "therapeutical agreement"; moments, when – by the nearness of concurrent experience of very intensive emotions – "encounter" gets possible. In that case, encounter may occur, when it is not necessary to analyse and provide with terms everything any longer. The experience of silence moves on a level, that does not have words and verbal speech any more.

There should not be procured an image of something bottomless, which is in danger to loose itself in depth. Rather the reflection on our dealing with silence can lead to recognice our therapeutical task: to put across particularly plenty of support to the patient during silence. And there is a 'point', at which the bottomline happens: the 'new' begins.

References:

Benenzon, R. (2000). Musicoterapia e psicoterapia verbale. La resistenza al contesto non verbale. In Larocca, F. (ed.), Atti del VI Convegno Internazionale 1999, Musicoterapia e danzaterapia per l'handicap – I mediatori analogici (p.19-30). Verona: Libreria Editrice Universitaria.

Dibelius, U. (1994). Kraft aus der Stille: Erfahrungen mit Klang und Stille in der neueren Musik. MusikTexte, Bd.55, p.9-14.

Lagler, M. (2001). Stille in der Musiktherapie. Unveröffentlichte Diplomarbeit im Kurzstudium Musiktherapie, Universität für Musik und darstellende Kunst, Wien

Pavlicevic, M. (1995). Growing into sound and sounding into growth: Improvisation grups with adults. The Arts in Psychotherapy, Bd.22/4, p.359-367.

Spiegler, M. (1991). Die Stille: Eine Charakterisierung des Phänomens und seine spezielle Bedeutung im musiktherapeutischen Prozeß. Unveröffentlichte Diplomarbeit, Fachhochschule der Stiftung Rehabilitation, Heidelberg.

Tannen, D./Saville-Troike, M. (ed.). (1995). Perspectives on Silence. New Jersey : Ablex Publishing Corporation

Zenck, M. (1994). Dal niente – Vom Verlöschen der Musik. Zum Paradigmenwechsel vom Klang zur Stille in der Musik des neunzehnten und zwanzigsten Jahrhunderts. MusikTexte, Bd.55, p.15-21.

The topic of this paper is taken from an unpublished diploma thesis, that was passed with distinction, of the music therapy study at the Viennese University of Music and Performing Arts.

Johann Sebastian Bach – as Psychotherapist

Johann Sebastian Bach – als Psychotherapeut

Borys Zats

"Bach is the only".
Frederick the Second, king of Prussia.

"...Bach's polyphony is of great use,
and what is the morally strengthening
influence on a man at large!"
Robert Schumann.

The life of a great creator and his works is a history of influence of genious spirit on people's souls, the history that is taking place nowadays. As it is known Iohann Sebastian Bach is a representative of the fifth generation of musicians' dynasty. Education and upbringing in the gymnasia in Ordruf, the traditions of which were based on the teaching of a great humanist, philosopher and teacher Yan Amos Komensky, influenced greatly the formation of Bach as a psychotherapist.

Yan Amos Komensky is a founder of didactics, the tutor of teachers and masters. While giving knowledge one should apply first of all to mental activity, to the roots of consciousness and by nourishing them excite feelings that together with thinking will strengthen the knowledge and memory.

There in classes of Ordruf gymnasia intellect and feelings came to equal development, and the harmonic confluence of them has been exciting the listeners for over three centuries.

Iohann Sebastian Bach owned the personal characteristics required for a psychotherapist. The member of the scientific Mizler's society, municipal organist from Lubenstein, George Andreas Zorge wrote in the dedication "to the prince of all clavir and organ performers": "The great musical virtue which Your Excellency possesses is also decorated with even the greater virtue – friendliness and sincere love of people."

As we know there are primary characteristics of a psychotherapist. Iohann Sebastian Bach was notable for his mental and physical health, he was an integral personality.

In his creative work and his actions he proceeded from imaginations about invariable ideal. He believed in the triumph of harmony in the world. He set

himself as an object new and new difficult aims and achieved them; and the process of creation was more pleasant and dear for him than the praise and success of the performance of his works.

Bach's personality is universal; he is both the composer and the performer (organist, clavecinist, violinist, viola player) and the teacher and the conductor. He was also an inventor and designer of musical instruments and master of acoustics.

He was happy and possessed constancy in love. Bach's nature as an artist derived much from the love experience, that is not accessible for an ordinary person. The topic of death in Bach's works is an inevitable feature of the life sacrament.

He did not avoid the struggle, and if necessary he was against the actions of temporal and church officials. He experienced the days of despair and suffered extreme privation. But at the same time as the poet of "Bachiana" Albert Schweitzer writes: "Bach is a mystery for us as the inner and outer persons in him are so far apart and independent that they do not have any relation to each other". "He is a person of two worlds; his artistic perception and creative work exist as if not coming into contact with commonplace life, being apart from it, music for him was a divine service."

The stream of creative thought was going in the depth of his consciousness, and his life full of everyday necessities was a superficial stream. Both of them seldom interflew in Bach's existence. It is called Bach's phenomenon. He was laconic but was able to cause interest of listeners and musicians, make them follow his will.

According to his contemporary – the teacher of Leipzig University Iohann Avraam Barnbaum, Bach was conversant not only in musical aesthetics but also in the laws of oratory.

German composer Paul Hindemit said that Bach's activity "is independent of anything around like the sun of the life which it endows with its rays".

Bach's contribution into musical therapeutics in particular and into musical culture in general is great. He introduced the tempered pitch of key musical instruments into music. And thanks to this clavier became universal. In this connection Robert Schumann wrote with surprise and respect: "Bach worked in the depths where the lamp of a miner was about to go out".

Together with the designer and constructor of the piano organist Gotfrid Zilbermann Bach took part in creation of piano and confirmed with his authority the value of this instrument as a musical instrument playing for the king of Prussia Frederick the Second in May, 1747.

He was one of the first to include a woman in the structure of the church chorus. With his suites for violoncello solo, for violoncello and clavier Bach promoted the transformation of the ancient viola da gamba into the violoncello. He was the first to introduce the performance of sacred music into the concert practice.

Bach's activity as a composer and performer-virtuoso and concert conductor presents the theory and practice of receptive group and individual musical therapeutics. Bach's influence on musicians as a teacher, guider of the orchestra and chorus presents the practice of active group and individual musical therapeutics. Bach's creative process, including his improvised creation as well as the teaching his pupils composition and improvisation appear to be active individual musical therapy and as a sort of autotraining.

Being arrested on the command of William Ernst, Saxon-Weimar Duke, in November-December 1717, Bach was in the cell of juridical department when he created music and even the preludes for "Organ Book". Such was Bach's autotraining in practice.

The elements of psychodrama are seen in the works written for soloists, chorus and orchestra. For example at the end of 1749, wishing to complete the discussion with the rector from Freiberg Mr. Bidermann who was the initiator of abolition of teaching music, Bach performed in Leipzig his cantata "Debates between Feb and Pan". This cantata reaches its aim, the listeners recognize the ignorant rector. The performance of this cantata can be also regarded as psychotherapic use of humour.

Possessing the fine sense of humour Bach applied this quality in his creative work. Such was the song about the smoking pipe from Anna Magdalena Bach's book in 1725. Such was the temporal cantata "Coffee Drink" written in 1732 which was openly intended for entertainment of audience, it comically reflected the debates of supporters and opponents of the new drink. "Bach composed the music, the author of which could be considered rather Offenbakh than the old cantor of St. Thomas Church", - resumed Albert Schweitzer.

Bach used in music as well as in life the elements of stress therapy In the blaming report of the county consistory in Armstadt city dated February 21, 1706: "We blame him for introduction of many strange tones in choral so that community was confused".

It is known that Bach used the stress psychotherapy on August 4, 1705 and was able to defend himself when six students of the church school of Armstadt tried to beat their teacher.

History keeps the illustration of his making insomnia remedy in 1842 for the Russian ambassador duke Keiserling. The duke said that he suffered insomnia and

wished his home musician Iohann Theofil Goldberg played him sweet melodies at such hours. In this case Bach like a chemist prepared an insomnia remedy for him – a cycle of masterly pieces "Goldberg Variations" which created the wanted by Keiserling state of "quiet and joyful comfort".

Monumental spiritual works of Bach are "passions": "Passions on John", "Passions on Matthew", "Magnificat", "Si-minor mass" belong to the direction of receptive group musical therapeutics and make up four highest peaks of mighty mountain chain – vocal and instrumental works by Bach. Indispensable participants of the action of "passions" are Evangelist (tenor), Jesus (bass), apostle Peter (bass), Pontiy Pilat (bass), high priests, false witnesses, chorus. Chorus is the acting person in the most strained scenes, this is the voice of people blessing the triumph of good. The usage of various plots, and first of all evangelic plots by Iohann Sebastian Bach in his compositions is one of the principles of modern positive psychotherapeutics – psychotherapic use of stories and parables.

Bach realizes the principles of tonato therapeutics both in his mighty spiritual works and in his spiritual and temporal cantatas and in a great number of temporal works. This is confirmed by a famous doctor, organist Doctor of Phylosophy and medicine Albert Schweitzer who admired Bach's view of human life which is completed with the death, as the act taken "peacefully" because the general eternal life is blessed by this act. The investigator characterizes this line as "through" one in Bach's musical phylosophy which is seen in his creative work since the young years until the last days. Bach's sorrow has no gloominess.

Much has been written about the influence of Bach's creation on listeners. Music experts help to watch the interchange of dramatic and lyric episodes, the change of musical structures. And at the same time all the attempts to interpret this music fail before the greatness of it. That is why every listener has his own "Bach".

Here appears one of the fundamental principles of therapeutics in general and psychotherapeutics in particular – the principle of individual approach. It is explained by the fact that there are hundreds of meanings in the deepest masterpieces which can influence the human spirit.

The familiar things are caught by one's own heart and thought, and behind this caught and as told, in the explanation to music arises something new, unknown, not transferred to any human conception marks and attracting by its uncognition.

What is the reason of such mighty influence of Bach-the creator on human souls? Perhaps, we shall never get the exhaustive explanation on this question. But some explanation still can be got from the facts of the creative biography of the genius and that is what S. Morozov writes about in his monography "Bach". Bach's best friend was a scientist – the theorist of music, composer and musician Iohann

Walter, the author of "Musical Lexicon" and "Instructions to the Composing of Music". Walter surpised his friend in erudition and shared with Bach the theoretical knowledge. Iohann Walter was the expert of teaching about affects. This teaching reflected the spirit of the epoch and influenced greatly the musical dramatic kinds of art. It was spoken about the influence of music on human feelings. According to the theory of affects, the methods of the composition of musical pieces as well as combination of means of musical art should be connected with one or another, but always determined, sensations. The componist who wishes to influence human hearts more deeply, should use the conformity of those connections. There were determined the main affect conditions that a musician must know: they were love, suffering, joy, anger, compassion, awe, pride, surprise. It is known that the outstanding scientist of that time, the theorist of music, composer and performer Iohann Walter was the connoisseur of that teaching. He was developing this theory in his coversations with I. S. Bach which lasted until late at night, and I. S. Bach brilliantly realized the teaching about affects in practice. Walter described in details the feelings expressed by means of music in his work "Musical Lexicon".

So we see that genius of Bach was armed with contemporary to him scientific theory.

So, taking into account:

- the totality of outstanding personality of I. S. Bach, the highest extent of harmonious development of rational and emotional spheres of psychics, benevolence, sincere love of people, courage, possession of methods of orator art, ability to subordinate groups of people (the public, orchestra players, chorus and students) by his universality;

- signs of mental and physical health during the whole period of creative life, tidiness in outward appearance, very high systematic capacity for work, extraordinary memory, modesty, ability to set himself important aims as an object and achieve them, presence of high level of critics to himself, ability to do his work at any circumstances (the so called "Bach phenomena");

- the innovation of Bach into modern musical culture and musical therapeutics, into creation of modern musical system of key instruments, into creation of modern piano, modern violoncello, introduction of woman's voice into the structure of church chorus, introduction of practice of performing concerts of spiritual music;

- the combination of methods and elements of methods of psychotherapeutics which Bach had applied: receptional group and individual musical therapeutics, active group and individual musical therapeutics, elements of psychodrama, positive psychotherapeutics, autotraining, stress therapeutics, positive use of humour, use of tanatotherapeutics, use of principle of individual approach in therapeutics, we can affirm that Bach's activity as the genius composer, conductor of chorus, conductor of orchestra, performer-virtuoso and teacher is the activity of psychotherapist.

In conclusion it should be stressed that great Iohann Sebastian Bach was able as much as possible to realise in practice the words of his older colleague and predecessor on the post of cantor of St. Thomas church in Leipzig, the outstanding composer Iohann Kunau, that music is "an orator who possesses the affects of all minds".

Thursday

18

On the importance of transitional objects for music therapy

Zur Bedeutung von Übergangsobjekten in der Musiktherapie

Edith Wiesmüller

Transitional objects, transitional phenomena and the intermediate room play an important role in the early development of children. This can be emphasized especially with young babies when they are separated from the mother. Winnicott compares the early *playing-room*-experiences between mother and child with those in a psychoanalytic session: The child feels strong and secure because of the presence of the mother. Very similar to the relationship between patient and psychoanalyst. As time passes, the child, respectively the patient starts developing the need for independence. As for theoretical and practical music therapy one can find lots of examples dealing with transitional objects.

The psychotherapeutically oriented music therapy was always concerned with the intermediate room , the *playing room*, where creativity starts. Which other medium apart from music could be more suitable for *play* and in creating *playing rooms*? In this respect, music as a medium for *play* or for building up *playing rooms* is perfect. *Play* can be considered as a form of coping with life and conflicts between internal needs and fantasies and external demands and realities. In music therapeutic interactions, i.e. *playing* within therapeutic relation succeeds directly contact. Therefore the methods of *Holding* and *Containing* are very important.

The *Holding*-method can be interpreted as an intuitive behavior of the music therapist. Through *Holding* the therapist assumes the so called self-functions of the patient. Often, the patient lacks a proper command of this functions. *Holding* happens in the music therapeutic *playing room* because music therapeutic *relation rooms* are created. Therefore a maternal atmosphere is important.

Through the *Containing*-method the music therapist takes on the function of a container. Apprehensive projected elements of the patient – so called *betaelements* – will be received and transformed into digestible *alphaelements.* This therapeutic situation can be compared to the early mother-child-relationship: Just like a baby, who is swamped with overwhelming emotions, and not able to handle them. Here, the mother transforms these emotions and makes them digestible for him. Often, in music therapy the presence and of the listening therapist alone can be considered as a form of *Containing*.

Transitional objects can be defined in different ways, for example as material objects – appearing with babies between their fourth and twelfth month. But also certain words or melodies can be viewed as transitional objects, as well as music in music therapeutic activities. Music can exist in special ways internally or externally because of its particular properties – it is real, but at the same time incomprehensible. Due to this properties it can function as transitional object. Music therapeutic experiences show, that even adults are using only one and same instrument within a long therapy process, through different development stages. This can lead ultimately to the point that the transitional object, i.e. the music instrument looses its meaning, like in similar development stages of early childhood regarding to transitional objects.

A case study in the field of music therapy with kids shows stages of development from transitional phenomena towards individual playing, and from playing towards a common play. Flute, guitar and vocals appear as main instruments as well as a situational song, which turned out to as a transitional character during the course of the early therapeutic units.

The topic of this paper is taken from an unpublished diploma thesis, that was passed with distinction, of the music therapy study at the Viennese University of Music and Performing Arts.

Inpatient Music therapy with adolescents in suicidal crisis

Stationäre Musiktherapie mit Jugendlichen in suizidalen Krisen

Andreas Wölfl

The central aim in clinical treatment of adolescents in suicidal situations is to stabilize the patient. In addition the focus lies on the diagnosis and therapy of the individual causes of suicidal behaviour.

• What are the general ways in music therapy to treat such a crisis?

• What specific methods are available for a music therapist?

Adolescents in suicidal crisis- general statements

It is part of life itself to reflect on life and also the possibilities of committing suicide. Most people have had such thoughts at some time in their life. There are examples for this in literature, films and plays.
During adolescence there is evidence of a significant rise in the number of suicidal attempts and suicides. Reasons for this are:

- Cognitive and emotional changes in the personal development of young people lead to confrontation with questions about life and death and possible ways of killing oneself.
- Differentiation of emotions and selfreflection might evoke selfdevaluation and selfhatred. (Braun-Scharm 2001)
- Psychosis and other major psychopathological disorders that are linked to a high suicidal risk appear for the first time in adolescence.

Adolescents are admitted to hospital if they are in serious danger of suicide, or if they have just failed in an attempt and lack support outside the hospital.

Clinical treatment aims to

- stabilize the patient
- find a diagnosis
- treat psychologically and psychotherapeutically
- develop adequate perspectives on life

In psychiatric units the patient is treated by a multiprofessional team. Music therapy is applied with specific indications and takes place in group as well as single therapy sessions. Typical aims of music therapy are:

- to give up isolation and get into contact (via music)
- to develop ways of communication and competence in relationships
- to work without words on the emotional background of the existing crisis
- to support social abilities and the integration in a group
- to promote and widen personal involvement in music and music therapy

Music therapy with adolescents in suicidal crisis

Music therapy is a creative form of psychotherapy and uses music as a means of experience. Therapeutic methods are improvisations on instruments that are easy to play (=active music therapy), listening to music (= receptive music therapy), therapeutic discussion and sometimes the broadening of musical knowledge and abilities.

There are different ways of treatment according to the actual state of the patient, his or her diagnosis, his or her age, the indication and the setting. I am in favour of a pragmatic mode of treatment that is based on the integration of analytical, gestalt- therapeutic, behavioral and solution-orientated techniques. The above combine methods of relaxation, problem-solving and activation of one´ s own experience and resources.

The main orientation during the first music therapy session is gained from

- the diagnosis
- the age of the patient
- the time frame

The music therapy process (*example*)

In the first phase of inpatient music therapy it is crucial to gain access to the adolescent and find a joint meaning in work, i.e. to set goals together and to agree on cooperating with one another. If the adolescent is prepared and able to accept therapeutic help or if he or she has an inborn interest in music and music therapy, it is possible to establish cooperation very quickly. Yet motivation and the ability to build up a relationship are required.

Often suicidal situations are connected with social withdrawal, isolation, lack of contact and loss of interest. The ability to build up contacts and relationships can be severly disturbed. The motivation for therapy might be fragile. Many patients do not look for help and do not believe that they can be helped. As a result, there might be deep insecurity and mistrust in therapeutic methods.

Music therapy, with its specific possibilities of active improvisation and receptive listening, offers a wide range of therapeutic approaches. (*example*)
Its nonverbal and playful character guarantees a creative way of dealing with problems and helps to attenuate the intensity of confrontation.
If the adolescent finds a way to access music therapy one should aim for a mutual goal. Often this is connected with the emotional background of the crisis and the search for modes of self-understanding and changes in behaviour patterns. The adolescent might long for relaxation and the ability to enjoy the world. Sometimes the therapeutic aim is limited to the activation of one´s own experience and resources, as is the case with psychotic patients.
The details of the relationship between the patient and the therapist are hidden amongst the playing and experimenting with music. Changes, disturbances and interruptions during the music therapy lessons might reveal the psychological and psychopathological background of the suicidal situation.
Analytical concepts of a corrective experience add to the treatment but have to be integrated into the acute handling of the crisis. The therapeutic relationship should be treated with respect and appreciation.

Music therapy and development of solutions

During the continuation of the therapeutic work one tries together with the patient to find access to the different ways of expressing the underlying problems. Often it is very helpful for improvisation to use imagining, roleplay, acting or painting as well. (*example*)
Receptive music therapy elements can be added and connected with a therapeutic discussion. Relaxed listening enables the patient to concentrate on himself and his inner response. This way of focussing encourages self-attention and perception of emotions. Different music therapeutic techniques such as guided sound journeys or resource-related imaginations might be helpful to let the patient experience sound step by step according to his own pace and therefore prevent overreacting. (*example*)
It is therefore very sensible when working with suicidal adolescents to combine active and receptive work and therapeutic discussions. The music therapeutic experiment enables them to face the background of the crisis on a symbolic level and try possible solutions first in a creative and playful manner. (*example*)
Inpatient treatment comes to an end when the patient´s condition is stabilized and he has developed realistic perspectives. If no further music therapy is planned- some psychiatric units for children and adolescents do in fact offer music therapy on an outpatient basis- music therapy comes to an end. The patient should be given the opportunity to speak about the experience he made and expressedly to say farewell. *Concluding summary of the specific ways of music therapeutic intervention in inpatient treatment of suicidal adolescents*

Effects of music therapy with mentally ill children and adolescents. A meta-analysis

Wirkung von Musiktherapie mit psychisch kranken Kindern und Jugendlichen. Eine Meta-Analyse

Christian Gold

The aim of this meta-analytic review was to examine the efficacy of music therapy with mentally ill children and adolescents, and to identify predictor variables, based on all previous relevant studies, published or unpublished. 11 studies with a total of 188 subjects met the inclusion criteria. The results of all studies were transformed into effect sizes and combined with a fixed effects model, weighting for sample size. The analysis yielded a medium positive effect size which is significant and statistically homogeneous. No reliable predictor variables were found. The effect is tentatively greater for subjects with multiple problems than for those with isolated problems. Effects on developmental and behavioural outcomes are tentatively greater than effects on self-concept and social skills. Eclectic approaches and psychodynamic and humanistic approaches are tentatively more effective than behavioural approaches. Various possible sources of bias were examined and deemed unlikely.

The findings suggest that music therapy is an effective intervention and can be recommended for routine clinical use. However, future research will be needed to address the question of moderator variables in greater detail.

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Music Therapy for Patients Suffering from Chronic Pain – Evaluation of an Interdisciplinary Approach

Musiktherapie bei chronischen Schmerzpatienten – Evaluation eines interdisziplinären Handlungsansatzes

Thomas K. Hillecke [1], Hans Volker Bolay[1], Anne Nickel[1], Hubert J. Bardenheuer[2]

Introduction

Born out of a practical need for care and treatment for patients with chronic pain, a therapeutic concept (Heidelberg model) was developed in the years from 1996 to 1999 and was later examined in a prospective, controlled and randomized effectivity study.

The project partners German Center for Music Therapy Research (DZM), Pain Center of the Clinic for Anesthesiology, University of Heidelberg and the Music Therapy Outpatient Center, University of Applied Science Heidelberg brought the disciplines medicine, music therapy, music psychology, psychology and psychotherapy into an interdisciplinary concept and research project. This enabled the team to combine important aspects of pain therapy according to the bio-psycho-social paradigm prevalent in pain research and to make these usable for music therapy. According to this understanding, music therapy is a form of artistic psychotherapy which is used as part of interdisciplinary pain therapy. It is suitable for all patients with chronic, non-malignant pain, especially patients with chronic headache and backache and concomitant affective and psychological stress.

The intervention strategy is based on the psychotherapeutic phase theory (Luger, 1995) which was used as a template for the therapy manual. The intervention aims to achieve improved emotional awareness and, in final consequence, a reduction of affective pain and pain intensity by addressing symptoms of psychosocial stress which accompany chronic pain.

Methodology

Modern empirical methods from medical and psychotherapeutic research were applied in the research project, yielding information on statistical significance as well as on clinical significance (Jacobsen et al, 1991; Kordy & Hannöver, 2000). This means of procedure offers two main advantages: firstly, these methods make

it possible to monitor all patients' progress individually, hereby serving as a model of standardized patient monitoring. Secondly, the relevance of patient change can be gauged drawing upon test-theoretical considerations. SES, VAS, OQ and other psychological questionnaires were used as instruments of outcome measurement.

Results

In the course of the cooperation between the Pain Center of the Clinic for Anesthesiology, University of Heidelberg, the Music Therapy Outpatient Center, University of Applied Science Heidelberg and the German Center for Music Therapy Research (DZM), about 100 patients have been treated so far. More than 40 patients took part in the research project.

The results of the project evaluation unequivocally confirm that it has been possible to double the improvement rate for patients with non-malignant pain by comparison to standard treatment using combined music therapy and standard treatment. 70 percent of patients from the group receiving music therapy treatment and 35 percent of patients from the control group profited from the treatment offered. Statistically significant and clinically relevant improvement was achieved in the music therapy group's pain and psychological well-being. The music therapy group scored lower on pain intensity and showed less affective stress while improvement rates for comorbidities such as anxiety and depression were higher than in the control group.

The study provides scientifically founded proof of the effectivity and efficiency of music therapeutic treatment according to the "Heidelberg model". In particular for highly affected patients who need specific pain therapeutic treatment, incorporating psychological methods of therapy into an interdisciplinary model can improve the quality of treatment. Music therapy according to the "Heidelberg model" is an effective means of helping patients suffering severely from chronic pain and of hereby improving their quality of living.

Discussion

The cost of treating chronic pain patients is a major problem in the health sector. There is a great need for effective and cost-efficient methods of treatment.

One major advantage of music therapeutic treatment is its relatively low cost. Music therapy for chronic pain is between 40 and 125 percent cheaper than comparable services from psychotherapists in private practice.

At the same time, patients profit from the intensive interdisciplinary setting. The interdisciplinary music therapeutic approach permits a broad view on the phenomenon of pain. In accordance to the music therapeutic understanding of

illness, the subjective suffering of patients with chronic pain is seen not as a psychopathological problem, but as a psychosocial health problem concomitant to this illness.

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